

05605

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

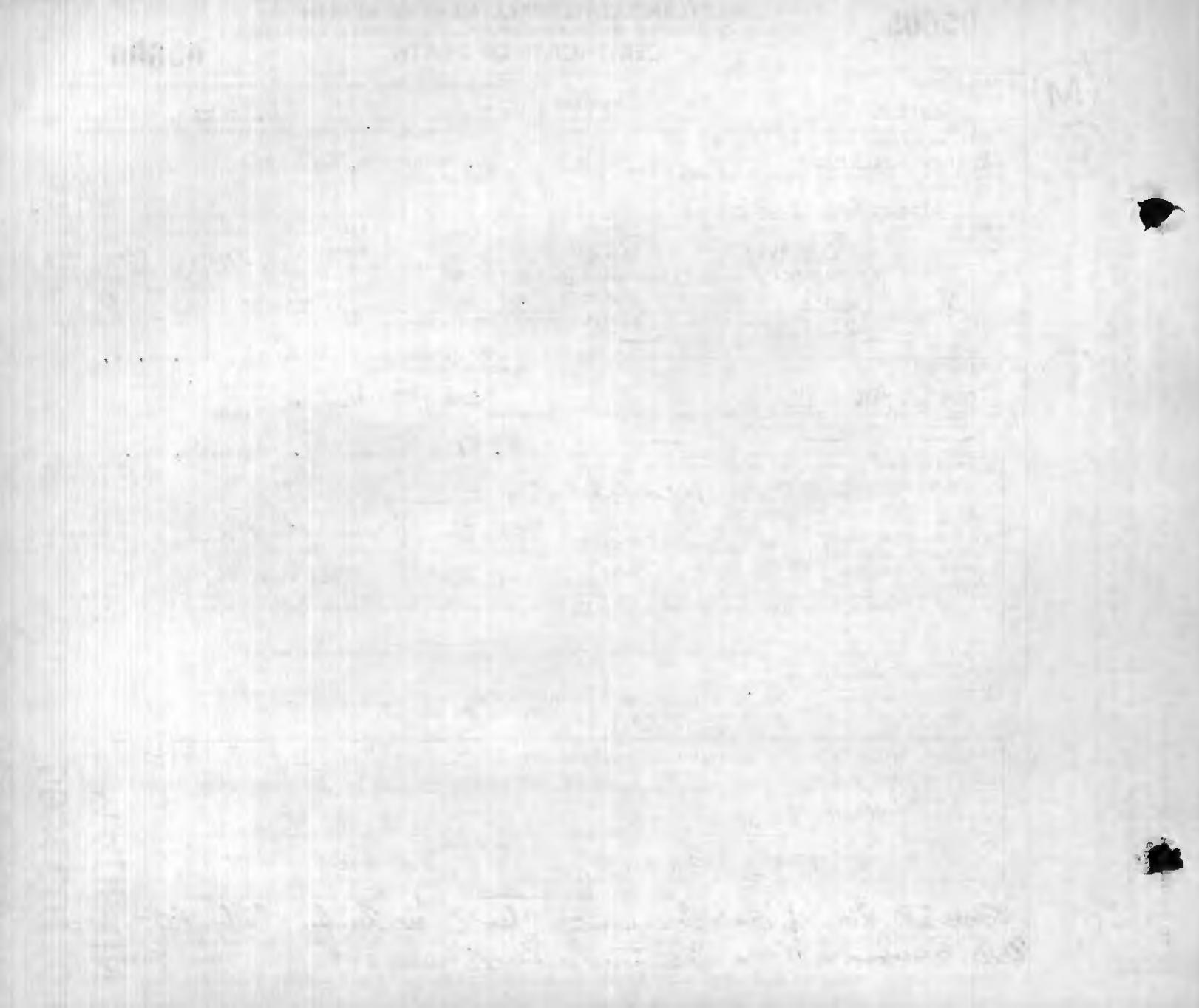
05600

may be furnished by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1. PLACE OF DEATH a. COUNTY Calvert		MAIDLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick		c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X St. Leonards, Maryland		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert County Hospital					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Baby	Middle Boy	Last Cavin	4. DATE OF DEATH May 17 1962	Month Day Year	
S. SEX M	6. COLOR OR RACE white	MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 5/16/62	9. AGE (In years lost birthday) — yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Tommy Cavin			14. MOTHER'S MAIDEN NAME Nina Hawkins	Address Mrs. Nina Cavin St. Leonards, M.		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —			16. SOCIAL SECURITY NO. —	17. INFORMANT	INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 761.5			Prematurity — J.			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)			Cesarean section (32 weeks) due 6 hours			
DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) (c)			Premature separation of placenta.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-16 1962 to 5-17 1962, that (I) (we) last saw the deceased alive on 19, and that death occurred at M, from the causes and on the date stated above.			22. DATE SIGNED			
22a. SIGNATURE Ronald C. Warkness			M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type) Ronald C. Warkness			22d. ADDRESS St. Leonards			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 18, 1962	23c. NAME OF CEMETERY OR CREMATORIAL Community Church Cemetery - Calvert - Md.	23d. LOCATION (City, town, or county) (State) Calvert - Md.		
24. FUNERAL DIRECTOR'S SIGNATURE R. C. Warkness Son - Funeral, Md.		ADDRESS	25a. REC'D BY REGISTRAR DATE MAY 21 1962	25b. REGISTRAR'S SIGNATURE Arthur S. House		



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FOR STATE
HEALTH DEPT.

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TO DEFENDANT: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 1 should be used as a burial-transit permit. File page 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05607		05602	
1. PLACE OF DEATH a. COUNTY <i>Salisbury</i> <i>Ches. Beach</i>		2. USUAL RESIDENCE Where deceased lived, if institution, residence before admission a. STATE <i>Md</i> b. COUNTY <i>Maryland</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS <i>8904 Flower Avenue</i>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH Last <i>5</i> Month <i>5</i> Day <i>23</i> Year <i>1962</i>	
5. SEX <i>M</i>		6. COLOR OR RACE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <i>March 8 09</i>		9. AGE (In years today) <i>53 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Fisherman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Insurance</i>	
11. BIRTHPLACE (State or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John</i>		14. MOTHER'S MAIDEN NAME <i>Mary Buril</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) <input type="checkbox"/> If yes give war or dates of service <i>No</i>		16. SOCIAL SECURITY NO. 17. INFORMANT <i>578-05-9464 Robert L. H. Lefinbaugh</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>782.4</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (d) cause last.		Address <i>Robert L. H. Lefinbaugh</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) <i>Was fishing when he suddenly collapsed</i>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <i>12:30</i> p.m. <i>5 23 62</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, etc., office bldg., etc.) <i>Ches. Beach</i> 20f. (City or town) (County) <i>Ches. Beach</i> (State) <i>Maryland</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE <i>H. W. Ward</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>H. W. WARD</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>5-26-62</i>	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>37th Funeral Cemetery</i>		22d. LOCATION (City, town, or county) <i>Prince George's County</i> (State) <i>Maryland</i>	
23. FUNERAL DIRECTOR <i>Francis J. Collins 3821-14th St. N.W. Wash. D.C.</i>		24a. REC'D BY REGISTRAR DATE <i>MAY 28 '62</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thorne</i>	

444-20-822

1
FOR STATE
HEALTH DEPT.

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05603

1. PLACE OF DEATH
a. COUNTY *Calvert* MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) *Upper Marlboro*

c. LENGTH OF STAY IN 1b *16*

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) *None*

2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)
a. STATE *Md.* b. COUNTY *Prince George*

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) *3837 Crain Highway, Upper Marlboro*

d. STREET ADDRESS *3837 Crain Highway*

e. IS RESIDENCE ON A FARM? *NO*

3. NAME OF DECEASED (Type or print) *James W. Ford* First *J* Middle *W*

4. DATE OF DEATH *5-30-62* Month *5* Day *30* Year *1962*

5. SEX *M* **6. COLOR OR RACE** *White* **7. MARRIED** **NEVER MARRIED** **8. DATE OF BIRTH** *12-21-40*

9. AGE (In years last birthday) *21 yrs.* **IF UNDER 1 YEAR** **IF UNDER 24 HRS.**
Months *0* **Days** *0* **Hours** *0* **Min.** *0*

10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) *Student* **10f. KIND OF BUSINESS OR INDUSTRY** *None* **11. BIRTHPLACE (State or foreign country)** *Maryland*

12. CITIZEN OF WHAT COUNTRY? *U.S.A.*

13. FATHER'S NAME *James W. Ford (Deceased)* **14. MOTHER'S MAIDEN NAME** *Gracie C. Ford*

15. WAS DECEASED EVER IN U.S. ARMED FORCES? *No* **16. SOCIAL SECURITY NO.** *None* **17. INFORMANT** *W. B. Bailey Hayward* Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] *Stroke*

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) *823X* DUE TO *Stroke*

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) *None*

DUE TO (c) *None*

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) *None*

19. WAS AUTOPSY PERFORMED? YES NO

20c. TIME OF INJURY Month, Day, Year **20d. INJURY OCCURRED** **20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)** **20f. (City or town)** **(County)** **(State)**
Hour a.m. *5:30* 1962 *While at work* *Upper Marlboro* *Calvert* *Md.*

21. I certify that I took charge of the remains described above. Held an Autopsy **Inspection** **Inquiry** **and in my opinion death resulted from:** **Natural causes** **Accident** **Suicide** **Homicide** **Undetermined manner**

CHIEF MEDICAL EXAMINER
ASSISTANT MEDICAL EXAMINER
DEPUTY MEDICAL EXAMINER
Address (Street, city, town, or county) *5730/62*

22a. BURIAL, CREMATION, REMOVAL (Specify) **22b. DATE THEREOF** **22c. NAME OF CEMETERY OR CREMATORIAL** **22d. LOCATION (City, town, or country)** **(State)**
Burial *6-2-62* *Union Methodist Church* *Upper Marlboro* *Md.*

23. FUNERAL DIRECTOR *Myrtle K. Rollins* ADDRESS *4339 Hunt Pl.* REC'D BY REGISTRAR *4-62* REGISTRAR'S SIGNATURE *Arthur S. Tamm*

VS. A15ME
SM 7/59

Rollins Funeral Home N.E., Wash. D.C.

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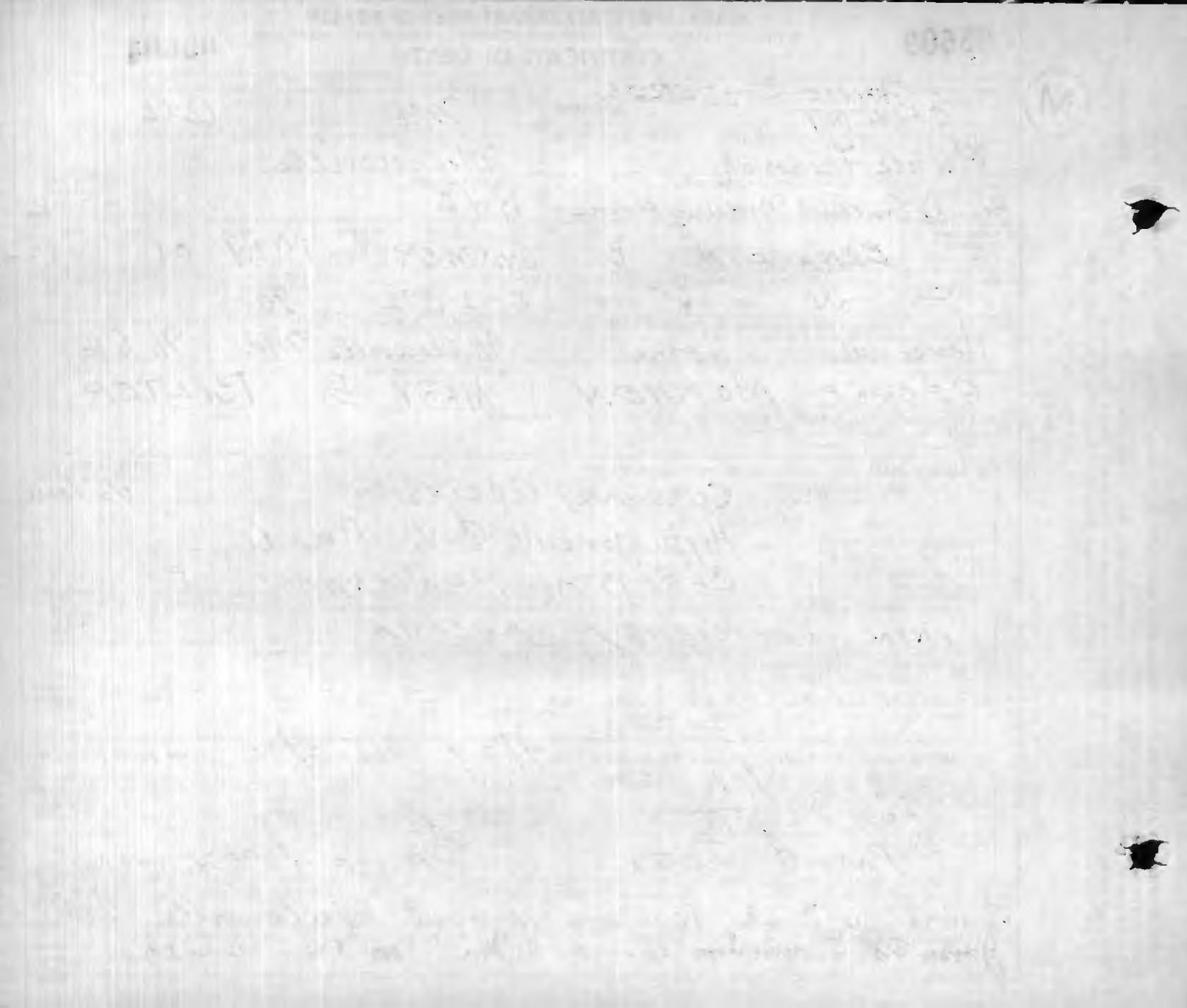
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05604

1. PLACE OF DEATH PRINCE FREDERICK a. COUNTY CHARLES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY C. Q. V	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Frederick Nursing Home		d. STREET ADDRESS R. F. D.	
3. NAME OF DECEASED (Type or print) ELISABETH		First B.	Middle GARDNER
4. DATE OF DEATH MAY 01 1962		Month	Day Year
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-12-1892
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
10c. BIRTHPLACE (State or foreign country) Millersville Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME GEORGE MCKNEW		14. MOTHER'S MAIDEN NAME MARY E. BOLTER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. 17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO CORONARY OCCLUSION INTERVAL BETWEEN ONSET AND DEATH 1/2 hour Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hyperleisure C. V. disease DUE TO (c) CEREBRAL HEMORRHAGE ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) IRON DEFICIENCY ANEMIA			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day 19	Year 1962
20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Millersville	(County) Charles
21. I certify that (I) (this hospital) attended the deceased from 4/29 1961 to 5/31 1962 that (I) (we) last saw the deceased alive on 5/19 1962 and that death occurred at M. from the causes and on the date stated above.			
22a. SIGNATURE PAGE C. SETT		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) PAGE C. SETT
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6-2-62	23c. NAME OF CEMETERY OR CREMATORIAL Baldwin Memorial	23d. LOCATION (City, town, or county) Millersville Md.
24. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sons Annapolis Md	ADDRESS 25a. REC'D BY REGISTRAR DATE 6/2 62	25b. REGISTRAR'S SIGNATURE Arthur S. Kline	



TO HOSPITAL by the hospital or attending physician and completely filled in by the funeral director.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05610

05605

1. PLACE OF DEATH a. COUNTY Calvert		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick		c. LENGTH OF STAY IN 1b 25 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert County Hospital		e. STREET ADDRESS Huntingtown	
3. NAME OF DECEASED (Type or print) OVENS		First W.	Middle GIBSON
4. DATE OF DEATH May 31 1962		Last	Month Doy Year
5. SEX Female		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
8. B. DATE OF BIRTH Aug. 15, 1880		9. AGE (In years last birthday) 81 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Wesely Lyons		14. MOTHER'S MAIDEN NAME Sarah E. Hardesty	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Polk B. Lyons, Huntingtown, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 442 X Hypertension C.K.R.		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Hour <input type="checkbox"/> a. m. <input type="checkbox"/> p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work -----	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) -----	
(County) -----		(State) -----	
21. I certify that (I) (this hospital) attended the deceased from 4-10 1962 to 31 May 1962 , that (I) (we) last saw the deceased alive on 30 May 1962 , and that death occurred at 8 P.M. from the causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE G. J. Weems		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) G. J. Weems		22d. ADDRESS Huntingtown, Maryland	
23a. BURIAL/CREMATION/REMOVAL (Specify) Burial		23b. DATE THEREOF June 3, 1962	
23c. NAME OF CEMETERY OR CREMATORIAL Miranda Memorial Cemetery		23d. LOCATION (City, town, or county) Huntingtown, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Hutchinson Funeral Home		ADDRESS Owings, Maryland	
25a. REC'D BY REGISTRAR -----		25b. REGISTRAR'S SIGNATURE Arthur S. Krause	



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05611

05606

1. PLACE OF DEATH

a. COUNTY

Calvert

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Owings

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

5. SEX

6. COLOR OR RACE

M

K

7. MARRIED NEVER MARRIED
WIDOWED DIVORCED

8. DAY OF BIRTH

May 11 1900

4. DATE
OF
DEATH

Month

Day

Year

5

23

1962

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10b. FATHER'S NAME

farmer

10c. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, No, or unknown) (If yes give rank or dates of service)

10b. KIND OF BUSINESS OR INDUSTRY

11. DEATHPLACE (State or foreign country)

Calvert

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

787,4

DUE TO

Conditions, if any, which
gave rise to immediate cause
(b)

(a), stating the underlying
cause last.

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Found dead in bed at 730 Am

INTERVAL BETWEEN
ONSET AND DEATH

20c. TIME OF INJURY Month, Day, Year

Hour a.m.

730

5/23

1962

19

62

White

Not White

at work

at work

19

21

Home

Indy

street

office bldg., etc.

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20d. EXTERNAL CAUSE WAS

PRIMARY or CONTRIBUTING

CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Found dead in bed at 730 Am

19. WAS AUTOPSY
PERFORMED?

YES NO

22a. BURIAL/CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

5-26-62

22c. NAME OF CEMETERY OR CREMATORI

Cooper's

22d. LOCATION (City, town, or country)

Dunkirk,

(State)

Md.

23. FUNERAL DIRECTOR

H. E. Sevell

— Prince Frederick, Md.

24a. REC'D BY REGISTRAR

MAY 31 '62

24b. REGISTRAR'S SIGNATURE

John S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any part of the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Chief Medical Examiner's Office along with form PMJ. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59



1
FOR STATE
HEALTH DEPT
M

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05612 05607

1. PLACE OF DEATH
a. COUNTY

Calvert

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Prince Frederick

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Calvert County Hospital

3. NAME OF
DECEASED
(Type or print)

WILLIAM

EDWARD

JONES

5. SEX

Male

6. COLOR OR RACE

Colored

WIDOWED

DIVORCED

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

4-15-37

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Labor

13. FATHER'S NAME

Norman Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT

(Yes, no, or unknown) (If yes give rank or date of service)

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a)

Gunshot wound of right upper chest

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY
PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

Shot in chest during altercation

20c. TIME OF INJURY Mon, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm,
Hour a.m. While at work Not While at work factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

12:20 p.m. May 24, 1962 House Owings, Calvert Co., Md.

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL
SIGNATURE

R. Breitenecker

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

NAME (Type) R. Breitenecker, M.D. 22c. NAME OF CEMETERY OR CREMATORIAL
REMOVAL (Specify) 22d. LOCATION (City, town, or country) (State)

Address (Street, city, town, or county)

22c. NAME OF CEMETERY OR CREMATORIAL *Eden* 22d. LOCATION (City, town, or country)

5-24-62

Calvert Md

23. FUNERAL DIRECTOR

ADDRESS

FE Sewell, Prince Frederick, Md

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

DATE MAY 31 '62

Cathar. S. Kline

TO DEPUTY: MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any copy is necessary, please execute the certificate, writing the word "pasting" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
5M 9 60



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any detail is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05613 05608

1. PLACE OF DEATH
a. COUNTY

Calvert
Buddington

MARYLAND

c. LENGTH OF STAY IN lb

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

3. NAME OF
DECEASED
(Type or print)

First

Middle

Neal

5. SEX

M

6. COLOR OR RACE

C

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

8. DATE OF BIRTH

3/27/1940

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Student

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Charlotte, No. Carolina

13. FATHER'S NAME

Ervin Neal

14. MOTHER'S MAIDEN NAME

Jessie Lee

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give rank or date of service

16. SOCIAL SECURITY NO.

17. INFORMANT

Ervin Neal

Address

4089 Minnesota Avenue, N.E.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

823 X DUE TO

Conditions, if any, which
give rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Heart attack due to embolism
of left leg at hip.
Head injuries

INTERVAL BETWEEN
ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

First accident

20c. TIME OF INJURY Month, Day, Year

Hour a.m.

p.m.

19

20d. INJURY OCCURRED While
at work Not While
at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

416

20f. (City or town)
(County) *Calvert* (State) *MD*

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL
SIGNATURE *H. W. Ward*

EXAMINER'S
NAME (Type)

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

6/4/62

23. FUNERAL DIRECTOR

Calvert Stewart

22c. NAME OF CEMETERY OR CREMATORIAL

Lincoln Memorial

ADDRESS

30 H Street, N.E.

22d. LOCATION (City, town, or country)

Suitland, Md.

(State)

5/30/62

DATE

4 '62

DATE

Arthur S. Kline



1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05609

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE		Maryland		b. COUNTY		Calvert	
Calvert				Maryland		Maryland		Calvert			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		X Barstow		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Barstow				X Barstow							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS							
3. NAME OF DECEASED (Type or print)		First SARAH		Middle PAKKEK		4. DATE OF DEATH MAY 23 1962		Month Year		Day	
5. SEX M		6. COLOR OR RACE N		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/10/1908		9. AGE (In years lost birthday) 57 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Benjamin Jones		14. MOTHER'S MAIDEN NAME Aliza Commodore									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO. 219-36-0937		17. INFORMANT Earnest Parker		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 443X DUE TO Conditions, if any which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HYPERTENSIVE & CARDIAC DISEASE		Address		19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 24, 1962 to May 22, 1962, that (I) (we) last saw the deceased alive on May 22, 1961, and that death occurred at 9 P.M. from the causes and on the date stated above.		22a. SIGNATURE Issam F. El-Damalouji, M.D.		M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 5/26/62			
22c. PHYSICIAN'S NAME (Type) Issam F. El-Damalouji, M.D.		22d. ADDRESS Prince Frederick, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 5/27/62		23c. NAME OF CEMETERY OR CREMATORIUM Browns		23d. LOCATION (City, town, or county) Calvert Co., Md.		24. FUNERAL DIRECTOR'S SIGNATURE Lorraine L. Sevall		25a. REC'D BY REGISTRAR DATE MAY 31 '62	
										25b. REGISTRAR'S SIGNATURE C. T. & T. Tamm	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT.

M
X

TO DEPT: MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05610

1. PLACE OF DEATH

a. COUNTY

Calvert

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Prince Frederick

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, if institution: Res denied before admission)

a. STATE

Md

b. COUNTY

Calvert

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Prince Frederick

d. STREET ADDRESS

e. IS RESIDENCE
ON A FARM?
YES NO

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

5. SEX

6. COLOR OR RACE

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

10a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)

10b. JOB, KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

13. FATHER'S NAME

MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES
(Yes, no, unknown) (If yes, give rank or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

18. CAUSE OF DEATH (Enter only one cause for line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
(IMMEDIATE CAUSE (e))

976X

DUE TO

(b)

DUE TO

(c)

Bullet wound of head which

entered from mouth.

Cancer of the stomach

INTERVAL BETWEEN
ONSET AND DEATH

18 mo

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY
PERFORMED?

YES NO

20e. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20f. PLACE WHERE INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20g. TIME OF INJURY Month, Day, Year

Hour a.m. 20d. INJURY OCCURRED While Not While

at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

5/14 1962 Home Prince Frederick Calvert Md.

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion

death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

5/14/62

ACTUAL
EXAMINER'S
NAME (Type)

H. W. WARD, OWINGS MD., Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or county) (State)

Burial May 16, 1962 St. Paul's Cemetery Prince Frederick - Calvert Co. Md.

23. FUNERAL DIRECTOR

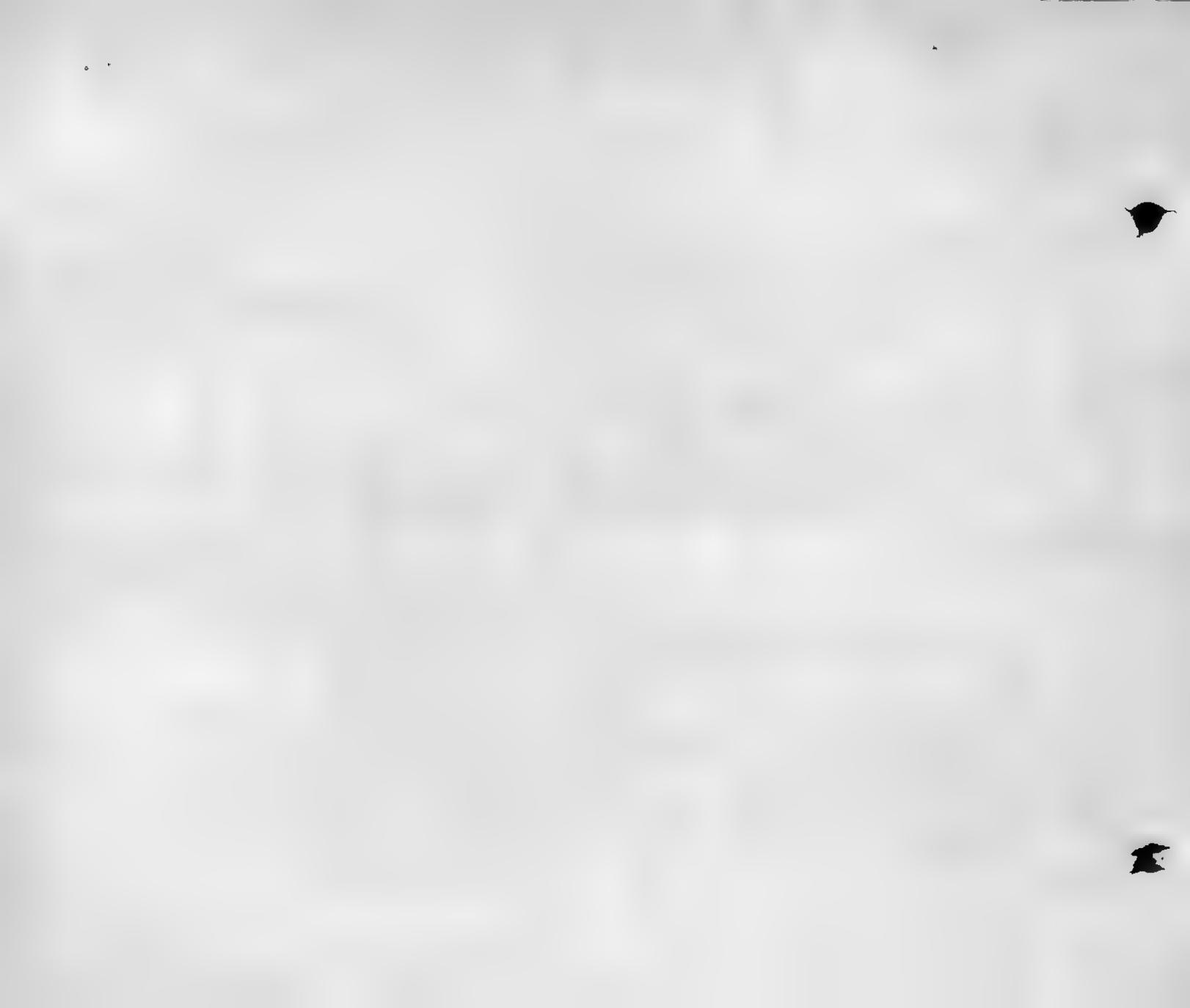
ADDRESS

REC'D BY REGISTRAR MAY 16 '62

24b. REGISTRAR'S SIGNATURE

Charles S. Kline

VS. AISM
5M 7/59



FOR STATE
HEALTH DEPT.

M

TO DEPT: MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05611

1. PLACE OF DEATH

a. COUNTY

Calvert

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Prince Frederick

c. LENGTH OF STAY IN 16

72 hr.

2. USUAL RESIDENCE (Where deceased lived, if institutional, Residence before admission)

a. STATE

b. COUNTY

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Washington

47 x 5

d. STREET ADDRESS

1530 11th St N.W.

IS RESIDENCE
ON A FARM?

YES NO

3. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Calvert Hospital

First Middle

3. NAME OF

(Type or print)

William

Ward

John

4. DATE
OF
DEATH

Month

Day

Year

5

8

1962

5. SEX

M

6. COLOR OR RACE

W

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

April 12, 1898

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Calvert Hospital

10b. KIND OF BUSINESS OR INDUSTRY

Commerce

11. BIRTHPLACE (State or foreign country)

Va

13. FATHER'S NAME

Walter T. Powell

14. MOTHER'S MAIDEN NAME

Daisy Hightaffer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or date of service)

RT

16. SOCIAL SECURITY NO.

30-20-84-13

17. INFORMANT

Address

Monica M. Powell 1530 11th St, N.W., Washington, DC

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

322.2

DOUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DOUE TO

(c)

Cardiac failure
Drinking alcohol
Dead on arrival at CCH

INTERVAL BETWEEN
ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Had been drinking for 4 days

19. WAS AUTOPSY
PERFORMED?

YES NO

2Dav EXTERNAL CAUSE WAS

PRIMARY or CONTRIBUTING CAUSE OF DEATH.

2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year

Hour a.m. p.m.

19

2Dd. INJURY OCCURRED

While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify)

1

22b. DATE THEREOF

5-11-62

5-11-62

22c. NAME OF CEMETERY OR CREMATORIAL

Andrew Chapel Church Cemetery, Vienna, Fairfax Co., Virginia

22d. LOCATION (City, town, or country) (State)

Vienna, Fairfax Co., Virginia

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

Raymond A. Ziska

Warner E. Pumfrey, Inc., Silver Spring, Maryland

DATE MAY 14 '62

DATE SIGNED

5/8/62



05617

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05612

1. PLACE OF DEATH a. COUNTY Calvert		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Calvert		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick		c. LENGTH OF STAY IN 1b Calvert County Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Huntingtown		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert County Hospital						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Alex		First	Middle	Last	4. DATE OF DEATH May 11	Month	Day	Year 1962
5. SEX Male		6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 12, 1881	9. AGE (In years lost birthday) 78 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Daniel Rice		14. MOTHER'S MAIDEN NAME Bettie Johnson						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-10-9591A		17. INFORMANT Emma Rice, Huntingtown, Md		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)		Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH		
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) St. Leonard	(County)	(State)	
21. I certify that (I) (this hospital) attended the deceased from _____ to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that death occurred at _____ PM, from the causes and on the date stated above.								
22a. SIGNATURE John L. V. Miller		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 5/11/62		
22c. PHYSICIAN'S NAME (Type) Joe Villarreal MD		22d. ADDRESS St. Edmonds						
23a. BURIAL, CREMATION, REMOVAL (Specify) 5-14, 62		23c. NAME OF CEMETERY OR CREMATORIAL St. Edmonds		23d. LOCATION (City, town, or county) Sunderland		(State) Md		
24. FUNERAL DIRECTOR'S SIGNATURE Lindsey Sewell, Prince Frederick		ADDRESS		25a. REC'D BY REGISTRAR DATE May 15 '62		25b. REGISTRAR'S SIGNATURE C. S. Thomas		



05618

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05613

1. PLACE OF DEATH a. COUNTY Calvert		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Calvert			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Willows		d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert County Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Joseph E.		First	Middle	4. DATE OF DEATH May 7		Month	Day	Year	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH April 13, 1905		9. AGE (In years last birthday) 57	10. IF UNDER 1 YEAR Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fisherman		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Anthony Schneider			14. MOTHER'S MAIDEN NAME Ida Kendrick						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO No		17. INFORMANT Mrs. Dorothy Schneider, Willows, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 153.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from 2/21/62 to 2/25/62, that (I) (we) last saw the deceased alive on 5/1/62, and that death occurred on 5/4/62 M, from the causes and on the date stated above.									
22a. SIGNATURE George J. Weems, M. D.		M.D.		ATTENDING PHYS <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED May 7, 1962		
22c. PHYSICIAN'S NAME (Type) George J. Weems, M. D.		22d. ADDRESS Huntingtown, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/10/62		23c. NAME OF CEMETERY OR CREMATORIAL Ft Lincoln		23d. LOCATION (City, town, or county) Bladensburg			
24. FUNERAL DIRECTOR'S SIGNATURE LEE FUNERAL HOME, 300 4th St. N.E.		ADDRESS		25a. REC'D BY REGISTRAR DATE MAY 9 '62		25b. REGISTRAR'S SIGNATURE C. J. Weems			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05619

CERTIFICATE OF DEATH

1. PLACE OF DEATH

a. COUNTY

Calvert

MARYLAND

b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town)

Dares Beach

c. LENGTH OF STAY IN lb

Life

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

/

3. NAME OF DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

May 7 1962

5. SEX

6. COLOR OR RACE

F

W

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

Apr. 18, 1879

9. AGE (in years
last birthday)

85

UNDER 1 YEAR

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Unworked

10b. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (County & State, or foreign country)

Calvert Co., Md

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John W. Skinner

14. MOTHER'S MAIDEN NAME

15. HAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give rank or date of service)

In

16. SOCIAL SECURITY NO.

(Type, no. or unknown) (If yes, give rank or date of service)

17. INFORMANT

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)795X DUE TO
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.(b) DUE TO
causa last.

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Hepatitis

old age - C.I. hemangioma - ad.

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour a.m. 19

p.m.

20d. INJURY OCCURRED While Not While
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from

19 to JAN

1962, that (I) (we) last

saw the deceased alive on May 7, 1962

, and that death occurred at 6 A.M.

from the causes and on the date stated above.

22a. SIGNATURE

Issam F. El-Damalouji, M.D.

22b. DATE SIGNED

May 7, 62.

22c. PHYSICIAN'S
NAME (Type)

Issam F. El-Damalouji, M.D.

22d. ADDRESS

O. A. Harkness & Son - Mutual, Md.

ADDRESS

23a. BURIAL, CREMATION
REMOVAL (Specify)

23b. DATE THEREOF

Burial May 9, 1962

23c. NAME OF CEMETERY OR CREMATORI

Central Cemetery

23d. LOCATION (City, town or county)

Baltimore - Calvert Co., Md

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

O. A. Harkness & Son - Mutual, Md.

ADDRESS

25a. REC'D BY REGISTRAR

MAY 9 '62

DATE

25b. REGISTRAR'S SIGNATURE

Arthur S. Kraus

NAME

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05620

05615

1. PLACE OF DEATH a. COUNTY Calvert		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Calvert			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings		c. LENGTH OF STAY IN 1b 17 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sunderland		d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Padgett's Nursing Home						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First XX EUGENE	Middle	Lost WELLS	4. DATE OF DEATH May	Month May	Doy 28	Year 1962	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 25, 1894	9. AGE (In years last birthday) 67 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Dys	12. IF UNDER 24 HRS Hours	13. IF UNDER 24 HRS Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY General Merchandise		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME David Wells				14. MOTHER'S MAIDEN NAME Agnes Cox					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yrs. no. or unknown)		16. SOCIAL SECURITY NO WWI 578-46-6003		17. INFORMANT Mrs. Verda Turner, Sunderland, Maryland		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) coronary occlusion atherosclerosis diabetes mellitus									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that (I) (this hospital) attended the deceased from May 21, 1962 to May 28, 1962, that (I) (we) last saw the deceased alive on May 27, 1962, and that death occurred at 1 A.M. from the causes and on the date stated above.									
22a. SIGNATURE Emily H. Wilson		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED				
22c. PHYSICIAN'S NAME (Type) Emily H. Wilson		22d. ADDRESS Sutton Rd.							
23a. BURIAL, CREMATION, REMOVAL, (Specify) Burial	23b. DATE THEREOF May 30, 1962	23c. NAME OF CEMETERY OR CREMATORIUM Mt. Harmony Cemetery		23d. LOCATION (City, town, or county) Nr. Owings, Maryland					
24. FUNERAL DIRECTOR'S SIGNATURE Hutchins Funeral Home	ADDRESS Owings, Maryland			25a. REC'D BY REGISTRAR DATE JUN 1 '62	25b. REGISTRAR'S SIGNATURE Arthur S. Evans				



FOR STATE
HEALTH DEPT.

TO DEF. PLEASE SIGN AND DATE
please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05621

05616

1. PLACE OF DEATH

2. COUNTY

Salisbury
Wicomico County

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

WIDOWED

DIVORCED

9. AGE (In years
last birthday)

10. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. MOTHER'S NAME

14. MOTHER'S MARRIED NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

18. CRUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (e)

823 X

DUE TO

(b)

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(c)

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FOR STATE
HEALTH DEPT.

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TO DEF
Please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05617

1. PLACE OF DEATH

a. COUNTY

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

MARYLAND

c. LENGTH OF STAY IN HOSPITAL

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

WIDOWED

DIVORCED

9. AGE (In years
less birthday)

10. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT

(Yes, no, or unknown)

(If yes give whereabouts of service)

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

782.4

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Cardiac failure

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20c. TIME OF INJURY

Month, Day, Year

Hour a.m.

5/15

20d. INJURY OCCURRED

While

at work

Not While

at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

Wash. D.C.

(County)

Wash. D.C.

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial May 19, 1962

22b. DATE THEREOF

May 19, 1962

22c. NAME OF CEMETERY OR CREMATORIUM

Congressional Cemetery

22d. LOCATION (City, town, or county)

Wash. D.C.

DATE SIGNED

5/15/62

23. FUNERAL DIRECTOR

Hutchins Funeral Home Owings Mills

ADDRESS

Owings Mills

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

Other S. Kuhn

DATE MAY 22 '62



1
FOR STATE
HEALTH DEPT.

TO DEP: MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05618

1. PLACE OF DEATH

a. COUNTY

b. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town]

MARYLAND

c. LENGTH OF STAY IN 1B

d. NAME OF HOSPITAL OR INSTITUTION [if not in hospital, give street address]

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

WIDOWED

DIVORCED

JUN 18 1941

9. AGE (In years
last birthday)
yrs.

10. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

11. KIND OF BUSINESS OR INDUSTRY

12. CITIZEN OF WHAT COUNTRY?

10a. FATHER'S NAME

11. BIRTHPLACE (State or foreign country)

U.S. A.

EUGENE DUNMORE

14. MOTHER'S MAIDEN NAME

INEZ Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Head struck completely
by a car.

INTERVAL BETWEEN
ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY
PERFORMED?

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

YES NO

20c. TIME OF INJURY
Month, Day, Year
Hour a.m.

20d. INJURY OCCURRED
Wh'ts Not Wh'ts
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)
(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL
SIGNATURE

CHIEF MEDICAL EXAMINER

DATE SIGNED

EXAMINER'S
NAME (Type)

M.D. ASSISTANT MEDICAL EXAMINER

22a. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIAL

22d. LOCATION (City, town, or country)

(State)

23. FUNERAL DIRECTOR

ADDRESS

24a. REC'D BY REGISTRAR

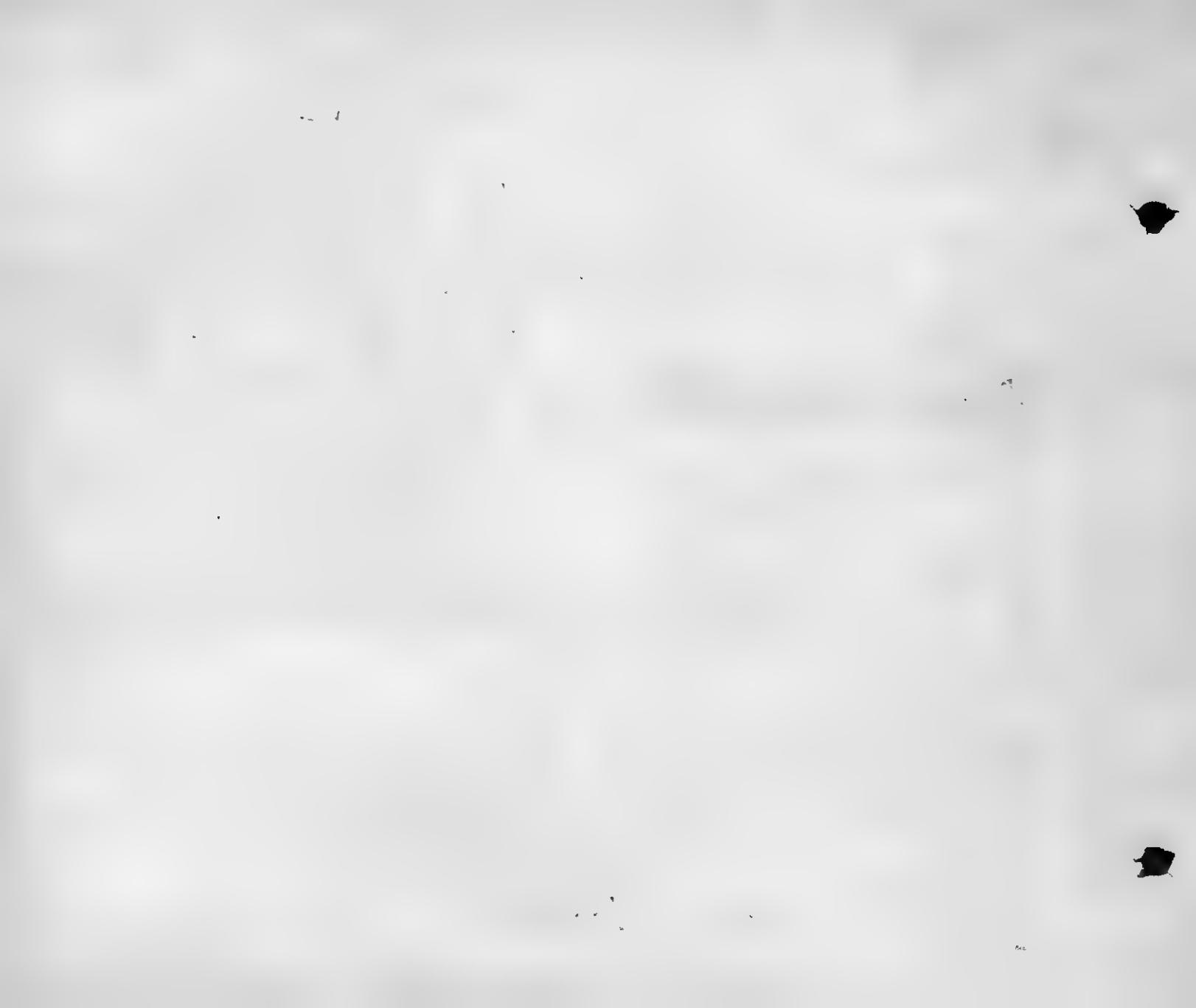
24b. REGISTRAR'S SIGNATURE

VS. A15ME
5M 7/59

STEWART & STEWART 913 F/L AVE

JUN 4 '62

Arthur & Thru



FOR STATE
HEALTH DEPT.

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05624

05619

1. PLACE OF DEATH
a. COUNTY

Calvert

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Lusby

c. LENGTH OF STAY IN lb

Life

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

2. USUAL RESIDENCE [Where deceased lived, if institution, Residence before admission]

b. STATE

Maryland

b. COUNTY

Calvert

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

X Lusby

d. STREET ADDRESS

e. IS RESIDENCE
ON A FARM?

YES NO

3. NAME OF
DECEASED
(Type or print)

First Middle

Last

4. DATE
OF
DEATH

Month Day Year

WILBERT

W. G.

WINK

May

28

19 62

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

Male

White

WIDOWED

DIVORCED

Mar. 3, 1925

9. AGE (in years
last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.

37

yr.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Carpenter

10b. KIND OF BUSINESS OR INDUSTRY

Shipyard

11. BIRTHPLACE (State or foreign country)

Baltimore, Md

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Percy Wink

14. MOTHER'S MAIDEN NAME

Mabel Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service)

yes WW II

16. SOCIAL SECURITY NO.

219-12-3224

17. INFORMANT

Mrs. Ruby S. Wink - Lusby - Calvert - Md.

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Carbon monoxide poisoning

INTERVAL BETWEEN
ONSET AND DEATH

973.1

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

20e. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Found in car with exhaust pipe into rear window

20c. TIME OF INJURY Month, Day, Year
Hour a.m.

9:00 AM 5/28/1962

20d. INJURY OCCURRED
While Not While
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

Highway

Lusby,

Calvert, Md.

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

ACTUAL
SIGNATURE

Peter W. Rieckert, M.D.

M.D. ASSISTANT MEDICAL EXAMINER
Medical Investigator
DEPUTY MEDICAL EXAMINER

DATE SIGNED

5/28/62

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

May 31, 1962

22c. NAME OF CEMETERY OR CEMATORIUM

Middleham Chapel Cem.

22d. LOCATION (City, town, or country)

Lusby - Calvert - Md

(State)

23. FUNERAL DIRECTOR

O. A. Harkness & Son - Mutual, Md.

ADDRESS

24e. REC'D BY REGISTRAR

JUN 1 '62

24b. REGISTRAR'S SIGNATURE

Arthur S. Harkness

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours of death.

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